MDR Tracking Number: M5-04-0688-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on November 3, 2003.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, joint mobilization, myofascial release, electrical stimulation, physical therapy, ultrasound therapy, therapeutic procedures, kinetic activities and physical medicine treatment were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This findings and decision is hereby issued this 19th day of February 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 01/14/03 through 02/12/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 19th day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pr

NOTICE OF INDEPENDENT REVIEW DECISION **Amended Letter**
Note: Decision

February 2, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-0688-01
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient sustained an injury on ___ while holding a bundle of tubing on top of a derrick and experienced neck and back pain. After an unsuccessful course of physical therapy, he had an MRI, which revealed a disc herniation. On 05/31/02, he underwent a lumbar laminectomy at L4-5 and had four weeks of postoperative physical therapy.

Requested Service(s)
Office visits, joint mobilization, myofascial release, electrical stimulation, physical therapy, ultrasound therapy, physical medicine treatment, therapeutic procedures, and kinetic activities from 01/14/03 through 02/12/03

Decision
It is determined that the office visits, joint mobilization, myofascial release, electrical stimulation, physical therapy, ultrasound therapy, physical medicine treatment, therapeutic procedures, and kinetic activities from 01/14/03 through 02/12/03 were medically necessary to treat this patient’s condition.

Rationale/Basis for Decision
The provider showed documentation to support the application of applied therapeutics from 01/04/03 through 02/12/03 that included active and passive modalities. Reviewed medical records show that this patient had not received appropriated medical and physical therapy applications following the 05/31/02 surgical procedure. It is not clear why this patient was not involved in any structured rehabilitation program from 09/17/02 through 01/12/03.

The patient remains in need of continued rehabilitation applications, as the proposed surgery is imminent. It is necessary for a post surgical rehabilitation program to be in place following the proposed two-level surgical fusion. It remains vital to the management of this patient that all parties involved be aware that surgical applications will be necessary due to the inappropriate amount of translation noted in the flexion/extension views performed on 07/17/03.

This patient has a chronic low back condition and is a failed low back surgical patient; any therapeutics must have a behavioral component and involve active, patient driven application to a capacity that can be tolerated by the patient. Therefore, It is determined that the office visits, joint mobilization, myofascial release, electrical stimulation, physical therapy, ultrasound therapy, physical medicine treatment, therapeutic procedures, and kinetic activities from 01/14/03 through 02/12/03 were medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- Atlas SJ, et al. *Surgical and nonsurgical management of lumbar spinal stenosis: four-year outcomes from the Maine lumbar spine study.* Spine. 2000 Mar 1; 25(5): 556-62.

- Bellamy R. Compensation neurosis: financial reward for illness as nocebo. Clin Orthop. 1997 Mar; (336): 94-106.

- Hansraj MD, KK, et al. Decompression, Fusion, and Instrumentation Surgery for Complex Lumbar Spinal Stenosis. Clinical Orthopaedics and Related Research 2001; 2001:18-25.

- Talbot, L. *Failed back surgery syndrome.* BMJ 2003; 327:985-986.

Sincerely,